U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 20 December 2002

Case No.: 2001-BLA-0977

In the Matter of:

HAROLD RAY SMITH,
Claimant

v.

PEABODY COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:[1]

Joseph H. Kelley, Esq.,
For the Claimant

Philip J. Reverman, Jr., Esq.,
For the Employer

BEFORE: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This proceeding arises from a claim filed by Harold Ray Smith for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901, et seq., as amended (Act). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs (OWCP). The regulations issued under the Act are located in Title 20 of the Code of Federal Regulations, and regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

Benefits under the Act are awarded to persons who are totally disabled due to pneumoconiosis within the meaning of the Act.

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[1] The Director, OWCP, was not represented at the hearing.

Survivors of persons who were totally disabled at their times of death or whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment, and is commonly known as black lung disease.

A formal hearing was held in Madisonville, Kentucky on July 10, 2002. Each of the parties was afforded full opportunity to present evidence and argument at the hearing, as provided in the Act and the regulations issued thereunder. The findings and conclusions that follow are based upon my observation of the appearance of the witness who testified at the hearing, and a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law. Post-hearing briefs were filed by the Claimant and the Employer and have been considered in this Decision.

I. STATEMENT OF THE CASE

The Claimant, Harold Ray Smith, filed two claims for benefits. His first claim was filed on March 26, 1990 (DX 38),[2] and denied by OWCP on September 7, 1990 (DX 38).[3] The Claimant did not appeal, and that Decision became final (DX 69).

The Claimant filed the present claim on February 14, 1997 (DX 1). On February 20, 1997, OWCP determined that Peabody Coal Company (Peabody) is the Responsible Operator (DX 21). A Notice of Claim was sent to Peabody on February 20, 1997 (DX 22). Peabody and its Insurance Carrier, Old Republic Insurance Company, filed an Operator's Response and Controversion on March 19, 1997 (DX 24). OWCP denied the claim on June 11, 1997 (DX 14). On July 16, 1997, the Claimant submitted additional medical evidence and requested reconsideration (DX 15). OWCP issued a Proposed Decision and Order - Memorandum of Conference on January 5, 1998, detailing the August 28, 1997 informal conference, and affirming the initial finding of denial issued by the District Director on June 11, 1997 (DX 37).

On January 13, 1998, the Claimant appealed, requested a complete medical evaluation, and requested a hearing before the Office of Administrative Law Judges (DX 17). OWCP granted the Claimant's request for an additional pulmonary function study on

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[2] In this Decision and Order, "DX" refers to the Director's Exhibits, "CX" refers to the Claimant's Exhibits, "EX" refers to the Employer's Exhibits, and "Tr." refers to the transcript of the July 10, 2002 hearing.

[3] OWCP denied benefits because the evidence did not support a finding of pneumoconiosis, causation, or total disability due to pneumoconiosis (DX 38).

January 29, 1998 (DX 19). OWCP transferred the case to the Office of Administrative Law Judges on April 20, 1998 (DX 39). A formal hearing was held before Administrative Law Judge Donald W. Mosser on September 23, 1998 (DX 42). Judge Mosser issued a Decision and Order Denying Benefits on May 26, 1999 (DX 46).[4] He found that the x-ray evidence and medical reports established a material change in the Claimant's condition since the prior denial, in that they proved pneumoconiosis arising out of coal mine employment. However, Judge Mosser denied benefits because he found that the medical evidence failed to prove that the Claimant had a totally disabling respiratory impairment, pursuant to [former] § 718.204(c).

On June 22, 1999, the Claimant appealed to the Benefits Review Board (DX 47). On July 12, 1999, the Claimant requested that the claim be remanded to the District Director (DX 49). On August 11, 1999, the Employer filed a Motion to Dismiss Appeal for Non-Prosecution (DX 50). By Order dated September 9, 1999, the Board dismissed the appeal and remanded the case to the District Director (DX 52). On November 3, 1999, the District Director issued a Proposed Decision and Order Denying Request for Modification (DX 58). On November 11, 1999, the Claimant appealed and requested a hearing before the Office of Administrative Law Judges (DX 59). On May 15, 2000, the District Director issued a Proposed Decision and Order - Denial of Benefits (DX 62). On May 24, 2000, the Claimant appealed and requested a hearing before the Office of Administrative Law Judges (DX 67), and again on March 7, 2001 (DX 66). The claim was transferred to the Office of Administrative Law Judges on July 3, 2001 (DX 68). A formal hearing was held in Madisonville, Kentucky on July 10, 2002.

II. ISSUES

The specific issues presented for resolution, as noted on Form CM-1025 and at the formal hearing are as follows (DX 68; Tr. 11-12):

1. Whether the Miner has pneumoconiosis as defined by the Act and the regulations;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner is totally disabled;

4. Whether the Miner's disability is due to pneumoconiosis;

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[4] Judge Mosser's Decision was received by the District Director on June 2, 1999 (DX 46).

5. Whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309(d);

6. Whether the evidence establishes a change in conditions and/or that a mistake was made in the determination of any fact in the prior denial per 20 C.F.R. § 725.310; and,

7. Whether res judicata applies in the current claim.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

The Claimant, Harold Ray Smith, was born on May 29, 1932 (DX 1), and was seventy years old at the time of the hearing. He has a twelfth-grade education (DX 1). The Claimant married Martha Orean (Fork) Smith on May 8, 1951 (DX 1, 7). He has no dependent children (DX 1). I find that the Claimant has one dependent for the purpose of augmentation of benefits, his wife, Martha Smith.

Smoking History

At the July 10, 2002 hearing, the Claimant testified that he does not currently smoke cigarettes (Tr. 20). According to the Claimant, he stopped smoking in 1962 (Tr. 21). He testified that he smoked at the rate of one pack of cigarettes every "couple of days" (Tr. 21). Judge Mosser did not make a finding as to the Claimant's smoking history in his May 26, 1999 Decision. At the September 23, 1998 hearing before Judge Mosser, the Claimant testified that he does not currently smoke cigarettes, but that he smoked for twelve years when he was younger (DX 42, pp. 23, 29). The examining physicians reported varying smoking histories. In his November 14, 2001 examination report, Dr. O'Bryan wrote that the Claimant does not currently smoke, but smoked "less than one pack of cigarettes per day from 1950 to 1963, thirteen years total" (EX 1). Dr. Simpao wrote in his October 3, 2001 examination report that the Claimant stopped smoking forty-three years ago [1958], ending a nine-year, one pack per day smoking history (CX 1). In his June 25, 1999 examination, Dr. Simpao reported that the Claimant "has a history of smoking one pack of cigarettes a day for eight years, but has not smoked for forty-three years [since 1956]" (DX 40). Dr. Simpao wrote in his June 23, 1998 examination report that the Claimant smoked one pack of cigarettes per day for eight years, and stopped smoking forty-two years ago [in 1956] (DX 40). In his March 4, 1997 examination report, Dr. Simpao wrote that the Claimant "has not smoked for the past 35 years [since 1962]" (DX 9). Dr. Gallo reported in his May 18, 1998 examination report that the Claimant smoked for "ten or twelve years" (DX 41). Based on the Claimant's testimony that he smoked for twelve years, and

the smoking histories reported by the examining physicians, I find that the Claimant smoked one-half pack of cigarettes per day for twelve years, for a total of six pack years.

Length of Coal Mine Employment

In his May 26, 1999 Decision and Order Denying Benefits, Judge Mosser found that the Claimant worked "at least thirty-six years" as a coal miner (DX 46). At the July 10, 2002 hearing, the parties stipulated to thirty-six years of coal mine employment (Tr. 11). This is supported by the CM-911a Employment History form (DX 2), W-2's for the years 1984 through 1990 (DX 5), and letters from Island Creek Coal Company, Pittsburg & Midway Coal Mining Company, and Peabody Coal Company (DX 4). As the Miner's last coal mine employment was in the Commonwealth of Kentucky, the law of the Sixth Circuit Court of Appeals applies.

Responsible Operator

Peabody Coal Company does not contest its designation as the Responsible Operator. This is supported by the evidence of record and I so find.

IV. MEDICAL EVIDENCE DATED SUBSEQUENT TO SEPTEMBER 7, 1990

The following medical evidence is dated subsequent to September 7, 1990, the date of the denial of the Miner's prior claim:

A. X-ray Studies[5]

Date	Exhibit	Doctor	Reading	Standards

[5] These x-ray interpretations, including re-reads of prior x-rays, were submitted following Judge Mosser's May 26, 1999 Decision Denying Benefits.

1.	11/14/01	CX 4	Brandon B reader[6] Board cert.[7]	3/3, q,p	Fair
2.	11/14/01	EX 1	O'Bryan	No pneumo.	Not noted
3.	11/14/01	EX 6	Wheeler	No pneumo.	Good
4.	6/2/99	DX 64	Wiot B reader Board cert.	No pneumo.	Good
5.	6/10/98	DX 64	Wiot B reader Board cert.	No pneumo.	Good
6.	5/7/96	DX 64	Wiot B reader Board cert.	No pneumo.	Good
7.	2/8/94	DX 64	Wiot B reader Board cert.	No pneumo.	Fair

[6] A "B reader" is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. See 42 C.F.R. § 37.51(b)(2).

[7] A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association.

B. Pulmonary Function Studies[8]

	Date	Exh.	Doctor	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Standards
1.	11/14/01	EX 1	O'Bryan	69/69"	1.78	2.28	65	78%	Good coop. and comp.; Three tracings
		Post-bronchodilator:			2.10	2.44	69	86%	

Validation: Dr. Fino wrote that this test is invalid, due to premature termination to exhalation and a lack of reproducibility in the expiratory tracings. He also wrote that there was a lack of an abrupt onset to exhalation, and that the MVV is invalid, because individual breath volumes are erratic, shallow, and less than 50% of the forced vital capacity. According to Dr. Fino, these spirometric values "certainly do not represent this man's maximum lung function" (EX 3).

Validation: Dr. Branscomb wrote that this test is invalid, due to poor effort. He wrote that a review of the tracings shows that the total lung capacity and residual volume values are unacceptable, and that the data is not acceptable or reproducible (EX 2).

2.	10/3/01	CX 2	Simpao	69/68"	1.82	2.59	79	70%	Good coop. and comp.; Three tracings
		Post-bronchodilator:			2.29	2.84	82	81%	

Comment: Reduced vital capacity and flow volume curve. Response is noted to bronchodilator. This test indicates a moderate degree of both restrictive and obstructive airway disease.

Validation: Dr. Branscomb wrote that the MVV is invalid, because only a single effort was done, due to coughing. He noted that the tracing shows the lack of a sufficiently long sequence of adequately deep and adequately fast breaths on the MVV (EX 4).

Validation: Dr. Fino wrote that this test is invalid, due to premature termination to exhalation, a lack of reproducibility in the expiratory tracings, and a lack of an abrupt onset to exhalation. He also wrote that the MVV is invalid, due to shallow breath sounds, less than 50% of the forced vital capacity, and erratic breath volumes (EX 5).

3.	6/2/99	DX 55	Simpao	67/69"	1.47	2.06	59	71%	Good coop. and comp.; Three tracings
		Post-bronchodilator:			1.86	2.31	73	81%	

Comment: Spirometry data is acceptable and reproducible. Patient effort, cooperation, and comprehension good. Numerous attempts to obtain matches to FEV_1 and FVC. Proventil used

[8] Because the physicians conducting pulmonary function studies noted varying heights, I must make a finding on the Miner's height. See Protopappas v. Director, OWCP, 6 B.L.R. 1-221, 1-223 (1983). Based on the height noted by a majority of the physicians, I find the Miner's height to be 69 inches.

as the bronchodilator. Tolerated testing well. Reduced vital capacity and flow volume curve. Response is observed to the bronchodilator. This test indicates a severe degree of both restrictive and obstructive airway disease.

Validation: Dr. Burki, a Board-certified Internist and Pulmonologist, wrote that these vents are not acceptable, due to equipment not meeting specifications (paper speed too slow) (DX 56).

Validation: Dr. Branscomb wrote that inspection of the tracings of this test shows that the MVV's are invalid, because the breaths were much too small and became smaller and smaller as breathing continued. He wrote that this shows a failure to provide appropriate breaths as the result of a misunderstanding or poor cooperation. According to Dr. Branscomb, the FEV_1 and FVC values are invalid, due to 12% to 26% difference between consecutive tests (EX 2).

Validation: Dr. Fino wrote that this test is invalid, due to a premature termination to exhalation, a lack of reproducibility in the expiratory tracings, and a lack of an abrupt onset to exhalation. He noted that the MVV is invalid, because individual breath sounds were shallow, erratic, and less than 50% of the forced vital capacity (EX 3).

4.	5/18/98	DX 41	Gallo	65/70"	.60	.63	19	95%	"Less than optimum effort;" Three tracings

Comment: Dr. Gallo wrote that this test shows "less than optimal effort," and noted that the tracings are not optimum (DX 41).

Validation: Dr. Fino wrote that this study is invalid, due to premature termination of exhalation, lack of an abrupt onset to exhalation, and a lack of reproducibility in the expiratory tracings (DX 41).

5.	6/10/98	DX 40	Simpao	66/69"	1.36	1.77	44	77%	Good coop.
			Post-bronchodilator:		2.12	2.47	48	86%	and comp.

Comment: Dr. Simpao wrote that these results are valid, based upon good effort, cooperation, and comprehension (DX 40).

Validation: Drs. Branscomb and Fino wrote that they could not reach a conclusion as to the validity of this study, due to lack of spirometric tracings (EX 9, 10).

6.	3/31/98	DX 36	Traughber	65/69"	2.60	8.93	42.5	29%	Good comprehen; Fair cooperation; Three tracings

Comment: Dr. Traughber wrote that these results do not meet intra-test reliability criteria, but are consistent with mild obstructive ventilatory deficit (DX 36).

Validation: Dr. Fino wrote that these results are invalid due to premature termination of exhalation, lack of an abrupt onset to exhalation, and a lack of reproducibility in the expiratory tracings (DX 41).

7.	2/9/98	DX 35	Traughber	65/69"	1.64	1.98	32.5	83%	Good coop. and comp.; Three tracings

Comment: Dr. Traughber wrote that the "[s]pirometry shows findings consistent with severe restrictive ventilatory deficit and meets the intratest reliability criteria" (DX 35).

Validation: Dr. Burki wrote that these results are not acceptable due to improperly performed studies (DX 35).

Validation: Dr. Fino wrote that these results are invalid, due to premature termination of exhalation, lack of abrupt onset to exhalation, and a lack of reproducibility in the expiratory tracings (DX 41).

8.	11/6/97	DX 34	Simpao	65/67"	1.90	2.39	73	79%	Good coop. and comp.; Three tracings

Validation: Dr. Burki opined that these results are not acceptable, due to less than optimal effort (DX 34). Dr. Fino opined that these results are invalid, due to premature termination of exhalation, lack of an abrupt onset to exhalation, and a lack of reproducibility in the expiratory tracings (DX 41).

9.	9/4/97	DX 29	Simpao	65/68"	1.48	1.90	58	78%	Good coop. and comp.; Three tracings

Validation: Dr. Burki opined that these results are not acceptable due to less than optimal effort (DX 29). Dr. Fino opined that these results are not acceptable, due to premature termination of exhalation, lack of an abrupt onset to exhalation, and a lack of reproducibility in the expiratory tracings (DX 41).

10.	5/28/97	DX 27	Simpao	64/69"	1.50	2.03	60	74%	Good coop. and comp.; Three tracings
		Post-bronchodilator:			1.67	2.15	77	78%	

Validation: Dr. Burki opined that these results are not acceptable due to less than optimal effort (DX 27).

Validation: Dr. Fino opined that these results are invalid due to premature termination of exhalation, lack of an abrupt onset to exhalation, and a lack of reproducibility in the expiratory tracings (DX 41).

11.	4/10/97	DX 28	Simpao	64/68"	2.23	2.83	46	79%	Good coop. and comp.; Three tracings

Validation: Dr. Burki opined that these results are not acceptable, due to less than optimal effort (DX 28).

Validation: Dr. Fino opined that these results are invalid, due to premature termination of exhalation, lack of an abrupt onset to exhalation, and a lack of reproducibility in the expiratory tracings (DX 41).

12.	3/4/97	DX 8	Simpao	64/68"	1.63	2.32	28	70%	Good coop. and comp.; Three tracings

Validation: Dr. Burki opined that these results are not acceptable, due to less than optimal effort (DX 8).

Validation: Dr. Fino found these results to be invalid, due to premature termination of exhalation, lack of an abrupt onset to exhalation, and a lack of reproducibility in the expiratory tracings (DX 41).

13.	5/7/96	DX 33	Simpao	63/69"	1.69	2.73	25	62%	Good coop. and comp. Three tracings
		Post-bronchodilator:			1.79	2.35	26	76%	

Validation: Dr. Burki found that these results are not acceptable, due to slow paper speed (DX 33).

Validation: Dr. Fino found these results to be invalid because of premature termination to exhalation, and lack of reproducibility in the expiratory tracings (DX 41).

C. Arterial Blood Gas Studies

	Date	Exhibit	Doctor	pCO_2	pO_2
1.	11/14/01	EX 1	O'Bryan	26.7 28.8	103.1 Resting 97.2 Exercise
	Comment:	Patient appeared short of breath when drawing resting arterial blood gas; almost appeared to be hyperventilating when drew exercise arterial blood gas, forcing air in and out quickly.			
2.	10/3/01	CX 1	Simpao	33.5	88.8
3.	6/10/98	DX 40	Simpao	32.3	70.6
4.	5/18/98	DX 41	Gallo	34	92
5.	5/28/97	DX 15	Simpao	30.2	85.7
6.	3/4/97	DX 10	Simpao	35.5	100.9

D. Narrative Medical Evidence

1. Dr. William M. O'Bryan, a Board-certified Internist, Pulmonologist, and Critical Care Physician, examined the Claimant on November 14, 2001, at which time he reviewed the Claimant's symptoms and his occupational (forty years coal mine employment; twenty-five years underground, fifteen years above ground), medical (arthritis, heart disease, diabetes mellitus, high blood pressure), smoking (does not currently smoke; smoked less than one pack of cigarettes per day from 1950 to 1963, thirteen years total), and family histories, performed a physical examination, pulmonary function study (abnormal; moderate restrictive ventilatory impairment confirmed by lung volumes), arterial blood gas study (abnormal; gas exchange normal, but analysis of pH and pCO_2 and bicarbonate suggests two processes; specifically, respiratory alkalosis and metabolic acidosis), and interpreted an x-ray (0/0), DLCO (normal when corrected for alveolar volume, and lung volumes (confirms restriction). Dr. O'Bryan diagnosed: (1) No evidence of pneumoconiosis; (2) Dyspnea, respiratory alkalosis, metabolic acidosis. Complex disorder, possibly related to medicines; (3) Organic heart disease, status post-CABG; and, (4) Moderate restrictive abnormality felt due to cardiac disease, previous CABG. In his opinion, the Claimant "does not have black lung pneumoconiosis," but his blood gases "indicate a complex metabolic problem, possibly related to one of the drugs that he is on." Dr. O'Bryan wrote that the Claimant's "restrictive abnormality would prevent him from working again in the coal mine." He opined that the Claimant's diabetic medications and his heart disease explain his dyspnea and restrictive ventilatory impairment (EX 1).

2. a. A “Visit Information Sheet” from the Coal Miners’ Respiratory Clinic, dated May 28, 2002, states that the Claimant received breathing treatment, including Proventil and heated aerosol (CX 3).

b. The record contains twelve “Visit Information” reports from the Coal Miners’ Respiratory Clinic, dated between July 27, 1999 and March 14, 2000. The Claimant was given breathing treatments consisting of Proventil and heated aerosol (DX 61).

3. a. Dr. Valentino Simpao examined the Claimant on October 3, 2001 for a routine physical. He reviewed the Claimant's symptoms and his occupational (forty years of coal mining experience; fifteen years of surface mining and twenty-five years underground; currently retired), medical (lung disease, heart disease, diabetes, high blood pressure, productive cough for the past seventeen years, shortness of breath for thirteen years, orthopnea, and wheezing), smoking (stopped smoking forty-three years ago, ending a nine-year, one pack per day smoking history) and family histories, and performed a physical examination, pulmonary function study (reduced vital capacity and flow volume curve; response is noted to bronchodilator; moderate degree of both restrictive and obstructive airway disease), arterial blood gas study (pCO_2 33.5; pO_2 88.8), TB skin test, and EKG. Dr. Simpao diagnosed: (1) Coal workers’ pneumoconiosis; (2) Emphysema; (3) Heart disease; and, (4) Hypertension (CX 1).

b. In a letter dated October 23, 2001, Dr. Simpao wrote that he reviewed Mr. Smith’s October 3, 2001 examination report. He opined that the Claimant’s “over 36 yrs (25 u.g. & 11 yrs. surface) of coal dust exposure is a sufficient amount of exposure to induce Pulmonary Impairment.” Dr. Simpao wrote that he based his opinion on the testing performed, symptomatology, and physical findings. According to Dr. Simpao, the Claimant’s pulmonary function test indicates a moderate degree of obstructive airway disease, and he also exhibited symptoms of wheezing, daily sputum production, and dyspnea on rest and exertion. He opined that the Claimant has a pulmonary impairment that would prevent him from performing his usual coal mine employment, and his thirty-six years of coal dust exposure is medically significant in his pulmonary impairment (CX 2).

c. Dr. Simpao examined the Claimant on June 25, 1999, for an annual physical. He reviewed the Claimant's symptoms and his occupational (“retired coal miner of forty years”), medical (“HTN, CWP, heart disease, and back problems”), smoking (“has a history of smoking one pack of cigarettes a day for eight years, but has not smoked for forty-three years”), and family histories, and performed a physical examination, pulmonary function study (“reduced vital capacity and flow volume curve with a response to the bronchodilator noted . . . severe degree of both restrictive

and obstructive airway disease"), resting oximetry, EKG, and TB skin test. Dr. Simpao wrote that the Claimant is very short of breath, especially on exertion and even talking, and noted that the Claimant is to return to the clinic once every three weeks and as needed for breathing treatments (DX 54).

d. Dr. Simpao examined the Claimant on June 23, 1998, at which time he reviewed the Claimant's symptoms and his occupational (forty years coal mine employment), medical, smoking (one pack of cigarettes per day for eight years; stopped smoking forty-two years ago [1956]), and family histories, and performed a physical examination, pulmonary function study, arterial blood gas study, and a TB test. Dr. Simpao diagnosed restrictive and obstructive airway disease, heart disease, and arthritis (DX 40).

e. Dr. Simpao examined the Claimant on March 4, 1997, at which time he reviewed the Claimant's symptoms and his occupational (forty years coal mine employment), medical, smoking (has not smoked for the past thirty-five years [since 1962]), and family histories, performed a physical examination, pulmonary function study, arterial blood gas study, and interpreted an x-ray (1/1). Dr. Simpao diagnosed coal workers' pneumoconiosis, 1/1. In his opinion, the Claimant has a moderate pulmonary impairment and his coal mine employment is medically significant to his pulmonary impairment. He did not provide answers to the questions of whether the Claimant's pulmonary impairment is related to pneumoconiosis and whether the Claimant has the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment (DX 9).

4. Dr. Thomas Gallo examined the Claimant on May 18, 1998, at which time he reviewed the Claimant's symptoms and his occupational (forty years of coal mine employment, twenty-five years underground), medical, smoking (ten or twelve years), and family histories, and performed a physical examination, pulmonary function study, and arterial blood gas study. Dr. Gallo diagnosed coronary artery disease, status post-coronary artery bypass graft, and a history of diabetes mellitus. He found no radiographic evidence of pneumoconiosis (DX 41).

E. Consultative Reports

1. a. Dr. Gregory Fino, a B reader and Board-certified Internist and Pulmonologist, issued a consultative report dated June 21, 2002, in which he reviewed Dr. Simpao's October 23, 2001 letter and October 3, 2001 pulmonary function test and arterial blood gas study, and Dr. Burton's interpretation of an x-ray dated October 3, 2001. He wrote that the October 3, 2001 pulmonary function test is invalid due to premature termination to exhalation, a lack of reproducibility in the expiratory tracings, and a lack of an abrupt onset to exhalation. According to

Dr. Fino, the values recorded for this spirometry "represent at least the minimal lung function that this man could perform, and certainly not this man's maximum lung function." Dr. Fino opined that the review of this additional medical information has not changed the opinions summarized in his January 12, 2002 report (EX 5).

b. Dr. Fino issued a consultative report dated January 12, 2002, in which he reviewed: eighteen interpretations of nine chest x-rays, dated from May 11, 1990 through November 14, 2001; fourteen pulmonary function tests, dated from May 11, 1990 through November 14, 2001; six arterial blood gas studies, dated from May 11, 1990 through November 14, 2001; three respiratory clinic examination reports, dated June 2, 1999, July 27, 1999, and March 14, 2000; and, a November 14, 2001 examination report by Dr. O'Bryan. Dr. Fino wrote that a review of the recent medical evidence has not changed his conclusions regarding the Claimant's condition. He opined that "there is insufficient objective medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis, and that there is no objective evidence of respiratory impairment" (EX 3).

c. Dr. Fino reviewed three medical reports, dated from May 11, 1990 to May 18, 1998; ten pulmonary function studies, dated from May 11, 1990 to May 18, 1998; four arterial blood gas studies, dated from May 11, 1990 to May 18, 1998; and, thirteen interpretations of four chest x-rays, dated from May 11, 1990 to May 18, 1998. He issued a consultative report dated August 31, 1998, in which he opined: (1) there is insufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis; (2) Mr. Smith does not suffer from an occupationally acquired pulmonary condition; (3) Mr. Smith has no respiratory impairment; and, (4) from a respiratory standpoint, Mr. Smith is neither totally nor partially disabled from performing his last mining job or a job requiring similar effort (DX 41).

d. Dr. Fino reviewed Dr. Simpao's June 23, 1998 report, and issued a supplemental report, dated November 3, 1998. He opined that Dr. Simpao's June 10, 1998 pulmonary function test is invalid because Dr. Simpao failed to provide tracings. Dr. Fino wrote that nothing in Dr. Simpao's most recent report changes his opinion that Mr. Smith does not suffer from pneumoconiosis, or any totally disabling respiratory impairment (DX 41).

2. a. Dr. Benjamin Branscomb, a Board-certified Internist, issued a consultative report dated May 22, 2002, in which he reviewed Dr. Simpao's October 23, 2001 letter and October 3, 2001 pulmonary function test and arterial blood gas study, and Dr. Burton's interpretation of an x-ray dated October 3, 2001. He opined that the Claimant's October 3, 2001 pulmonary function test "could be interpreted as supporting the presence of some form of

temporary, intermittent, or continuing obstructive airways disease." He wrote that he is unable to make a diagnosis of obstructive airways disease, due to the variation between the Claimant's previous ten or eleven pulmonary function tests and this test, the absence of clinical syndromes described in the Claimant's past medical reports, and Dr. Branscomb's "lack of confidence in the history of exposure to tobacco or to coal mine dusts" (EX 4).

b. Dr. Branscomb issued a consultative report dated January 7, 2002 in which he reviewed: Dr. Wiot's interpretations of four x-rays, dated February 8, 1994 through June 2, 1999; Dr. Simpao's June 2, 1999 pulmonary function test, a June 2, 1999 assessment from the Respiratory Clinic; Dr. Simpao's June 25, 1999 annual physical of the Claimant; and, Dr. O'Bryan's November 14, 2001 comprehensive exam, including a pulmonary function test and an arterial blood gas study. According to Dr. Branscomb, the opinions he expressed in his earlier letters are unchanged and are supported by the additional medical evidence. He opined that, "if there is any pulmonary impairment, it is the result of cardiovascular disease, not COPD, CWP, asthma, or other primary pulmonary disease." He also wrote that there may be "an additional metabolic component," resulting from "incompletely controlled diabetes and/or heart failure." In his opinion, there is no objective data indicating the presence of any primary pulmonary disease. He explained that it is "exceedingly common" and "usual" to have restrictive and obstructive impairments in a person with chronic left ventricular failure, an enlarged heart, and a previous sternum splitting operation. According to Dr. Branscomb, the hyperventilation seen during arterial blood testing by one doctor but not by another can be explained by "fear, anxiety, pain, or some other non-medical process." He wrote the impression of dyspnea or difficult breathing noted by some observers is "most likely due to observation of hyperventilation." Dr. Branscomb opined that coal mine dust exposure, or, assuming it is present, coal workers' pneumoconiosis, did not aggravate the Claimant's cardiovascular disease, or in some other way contribute directly or indirectly to the Claimant's symptoms and impairments (EX 2).

c. Dr. Branscomb reviewed three medical examination reports, dated from May 11, 1990 to May 18, 1998; ten pulmonary function studies, dated from May 11, 1990 to May 18, 1998; four arterial blood gas studies, dated from May 11, 1990 to May 18, 1998; and, twelve interpretations of four chest x-rays, dated from May 29, 1989 to May 28, 1997. He issued a consultative report, dated August 10, 1998, in which he opined: (1) Mr. Smith has no coal workers' pneumoconiosis or dust-related disorder or impairment; (2) there are no objective findings of a respiratory impairment, total or otherwise; (3) any impairment he may have is obstructive in nature, and due to cigarette smoking and not dust-related; (4) he has totally disabling cardiovascular and orthopedic impairments; and, (5) his heart is enlarged and his shortness of

breath and exercise intolerance are compatible and suggestive of his severe coronary disease and previous myocardial infarction (DX 41).

d. Dr. Branscomb reviewed Dr. Simpao's June 23, 1998 report, and issued a supplemental report, dated September 15, 1998. He opined that Dr. Simpao's June 10, 1998 pulmonary function test is invalid, because Dr. Simpao failed to provide tracings. He also wrote that the test is highly suspect, due to the abrupt fall in values after eight years of consistent values, and the abrupt improvement after the administration of a bronchodilator. Dr. Branscomb wrote that there is no credible evidence to support a finding of pneumoconiosis or a respiratory impairment (DX 41).

VI. DISCUSSION AND APPLICABLE LAW

Modification of a Duplicate Claim

Pursuant to § 725.2, all claims that were pending before the revision of the Act on January 19, 2001 shall be decided under the pre-revision version of § 725.309. This claim was pending at the time of the revision, thus the pre-revision language of the Act will be applied.

Twenty C.F.R. § 725.309(d) provides:

> In the case of a claimant who files more than one claim for benefits under this part, the later claim shall be merged with the earlier claim for all purposes if the earlier claim is still pending. If the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the deputy commissioner determines that there has been a material change in conditions or the later claim is a request for modification and the requirements of § 725.310 are met.

Twenty C.F.R. § 725.310(a) provides:

> ...upon the request of any party on the grounds of a change in conditions or because of a mistake in a determination of fact, the deputy commissioner may, at any time before one year from the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

The instant claim is a request for modification of the denial of benefits issued in the Miner's second claim, which is a duplicate claim. In a modification case, the claimant must show a "change in conditions," a less stringent standard than the

"material change in conditions" standard required in a duplicate claim. Because the claim in which the Claimant is requesting modification is a duplicate claim, the standard of review must be the same standard required in a duplicate claim. To use the lesser standard would frustrate the intent and purpose of the Act by allowing a claimant to circumvent the regulations and invoke the lesser standard simply by requesting modification after the denial of his duplicate claim.

As the Miner's last coal mine employment was in the Commonwealth of Kentucky, the law of the Sixth Circuit Court of Appeals applies. For cases arising in the Sixth Circuit, Sharondale Corp. v. Ross, 42 F.3d 993, 19 B.L.R. 2-10 (6th Cir. 1994) controls. In Sharondale, the Court adopted the following standard for determining whether a miner has established a material change in conditions:

> The ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

Accordingly, I will review the recent medical evidence under the duplicate claim standard as stated in Sharondale. The "recent medical evidence" is that medical evidence dated subsequent to September 7, 1990, the date that the Claimant's prior claim was denied. This evidence will be reviewed in order to determine whether a material change in conditions has been established. If a material change in conditions is established, then all the evidence of record must be reviewed. Judge Mosser issued the previous denial because the Claimant failed to establish total disability due to pneumoconiosis. The Claimant must now establish that he is totally disabled due to pneumoconiosis, the element of entitlement previously adjudicated against him. If he is successful, then he will have shown a material change in conditions, in which case the entire record will be reviewed.

Total Disability

Since this claim was filed after March 31, 1980, it must be adjudicated under the regulations at 20 C.F.R. § 718, et seq. The criteria for establishing total disability due to pneumoconiosis are contained in § 718.204(b)(2). Section 718.204(b)(2) permits a finding of total disability when there are pulmonary function studies with results equal to or below the table values, arterial blood gas studies meeting the table values, or where a physician

exercising reasoned medical judgment, based on medically acceptable clinical and laboratory techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work.

None of the six arterial blood gas studies produced values meeting the table values. The record contains the results of thirteen pulmonary function tests taken since September 7, 1990. Ten of the thirteen pulmonary function tests produced qualifying values. However, all ten tests have been found invalid by reviewing physicians.

The technician administering the November 14, 2001 pulmonary function test noted good cooperation and comprehension (EX 1). Drs. Fino and Branscomb reviewed the test data and tracings and opined that the test is invalid. Dr. Fino wrote that the test is invalid due to premature termination to exhalation and a lack of reproducibility in the expiratory tracings. He opined that there was a lack of an abrupt onset to exhalation, and that the MVV is invalid, because individual breath volumes are erratic, shallow, and less than 50% of the forced vital capacity. According to Dr. Fino, these spirometric values "certainly do not represent this man's maximum lung function" (EX 3). Dr. Branscomb wrote that this test is invalid, due to lack of effort. Specifically, he noted that a review of the tracings shows that the total lung capacity and residual volume values are unacceptable because the vital capacity is invalid. He noted that this test is not acceptable or reproducible, as evidenced by the variations in the flow volume loop (EX 2). Drs. Fino and Branscomb thoroughly reviewed the values and tracings, and cogently stated the reasons for their conclusions. As such, I find their opinions are entitled to more weight than that of the administering technician. In assessing the reliability of a study, an Administrative Law Judge may accord greater weight to the opinion of a physician who reviewed the tracings. Street v. Consolidation Coal Co., 7 B.L.R. 1-65 (1984). If the Administrative Law Judge credits a consultant's opinion over one who actually observed the test, a rationale must be provided. Brinkley v. Peabody Coal Co., 14 B.L.R. 1-147 (1990).

Dr. Simpao's June 2, 1999 test produced qualifying values but was found to be invalid by Drs. Burki, Branscomb, and Fino. Dr. Burki wrote that the test is invalid because the paper speed was too slow in the equipment used (DX 56). Dr. Branscomb opined that the MVV is invalid, because of poor cooperation or comprehension, as evidenced by the small breaths on the tracings. He also noted that the FEV_1 and FVC values are invalid due to a 12% to 20% difference between consecutive tests (EX 2). Dr. Fino reviewed the tracings and values and opined that the test is invalid "because of a premature termination to exhalation and a lack of reproducibility in the expiratory tracings." He also noted

a lack of an abrupt onset to exhalation, and an invalid MVV, due to shallow and erratic breath volumes (EX 2). Drs. Burki, Branscomb, and Fino conducted a thorough review of the tracings and reported values, and stated the reasons for their conclusions. Although they did not observe the test, all three physicians have specialized diagnostic skills as Board-certified Internists. I accord their opinions more weight than that of Dr. Simpao because he did not state the reasons for his conclusion that the Miner's cooperation and comprehension of the test was good and because Dr. Simpao lacks similar specialized diagnostic skills.

Dr. Gallo noted that his May 18, 1998 test shows less than optimal effort, and that the tracings are not optimum. Dr. Fino reviewed the test and also found it be invalid (DX 41). Although this test produced qualifying values, it is invalid, based upon less than optimal effort and tracings.

Dr. Simpao's June 10, 1998 test is invalid, because he did not provide tracings, as noted by Drs. Branscomb and Fino. Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. Estes v. Director, OWCP, 7 B.L.R. 1-414 (1984).

Dr. Traughber's February 9, 1998 test produced qualifying values, and he noted that the test "meets the intratest reliability criteria" (DX 35). Dr. Traughber failed to state why the test meets intratest reliability criteria, or what is included in this criteria. Drs. Burki and Fino reviewed the test and found it to be invalid. Dr. Burki opined that the test is invalid because it was improperly performed, as no volume/time tracing is included for the FEV_1 and FVC (DX 35). Dr. Fino wrote that the test is invalid due to premature termination of exhalation, lack of an abrupt onset to exhalation, and a lack of reproducibility in the expiratory tracings (DX 41). He also noted that the MVV is invalid, due to erratic, shallow individual breath volumes that were less than 50% of the forced vital capacity, and a breathing frequency that was less than 60 breaths per minute (DX 41). I accord greater weight to the opinions of Drs. Burki and Fino, because they reviewed the test data and thoroughly stated the reasons for their conclusions, while Dr. Traughber failed to explain why the test meets intratest reliability criteria.

Dr. Simpao's November 6, 1997 test produced qualifying values, but the technician noted that matches could not be obtained for the FEV_1 and FVC values. Drs. Burki and Fino opined that this test is invalid. Dr. Burki noted inconsistent effort, and Dr. Fino noted premature termination of exhalation, lack of an abrupt onset of exhalation, and a lack of reproducibility in the expiratory tracings (DX 41). Likewise, Dr. Simpao's September 4, 1997, May 28, 1997, and March 4, 1997 tests produced qualifying values, but were invalidated by Drs. Burki and Fino for the same reasons.

Additionally, Dr. Simpao's May 7, 1996 test produced qualifying values, but was invalidated by Drs. Burki and Fino. Dr. Burki noted slow paper speed (DX 33), while Dr. Fino found the results to be invalid due to premature termination to exhalation, and lack of reproducibility of the expiratory tracings (DX 41). Because Drs. Burki and Fino thoroughly reviewed the tests and tracings and stated the reasons for their conclusions, I credit their opinions over the observations of the technician performing the study. Additionally, Drs. Burki and Fino are Board-certified Internists and Pulmonologists, while Dr. Simpao does not have similar specialized skills.

Based upon the foregoing, I find that the ten pulmonary function tests which produced qualifying values are invalid. The Board has held that it is the Claimant's burden, pursuant to § 718.204, to establish total disability due to pneumoconiosis by a preponderance of the evidence. See Baumgartner v. Director, OWCP, 9 B.L.R. 1-65, 1-66 (1986); Gee v. Moore & Sons, 9 B.L.R. 1-4, 1-6 (1986) (en banc). Based upon the lack of valid pulmonary function tests and the nonqualifying arterial blood gas studies, I find that the pulmonary function tests and arterial blood gas studies do not support a finding of total disability.

The evidence since the prior denial contains the opinions of four physicians who address whether the Claimant is totally disabled due to pneumoconiosis.

Drs. O'Bryan, Fino, and Branscomb opined that the Claimant is not totally disabled due to pneumoconiosis. Dr. O'Bryan, a Board-certified Internist, Pulmonologist, and Critical Care Physician, examined the Claimant and opined that the Claimant's diabetic medications and heart disease caused dyspnea and a restrictive ventilatory impairment, which would prevent the Claimant from working again in the coal mine (EX 1). He opined that the Claimant's diabetic medications and heart disease explain his dyspnea and restrictive ventilatory impairment. Dr. O'Bryan conducted a physical examination, took histories, and administered a pulmonary function test, arterial blood gas study, and interpreted an x-ray. He stated the reasons for his conclusions and indicated the tests upon which he relied in making his diagnosis. As such, I find his opinion is reasoned, documented, and entitled to substantial weight.

Dr. Fino, a B reader and Board-certified Internist and Pulmonologist, issued four consultative reports, in which he opined that the Claimant is not totally disabled. Dr. Fino reviewed medical reports, pulmonary function tests, and arterial blood gas studies dated from 1990 through 2001. Although he did not personally examine the Claimant, his consultative reports state the reasons for his conclusions and provide the documentation upon which he relied in forming his opinion. As such, I find his

opinion is reasoned, documented, and entitled to substantial weight. A nonexamining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician, or by the evidence considered as a whole. Newland v. Consolidation Coal Co., 6 B.L.R. 1-1286 (1984); Easthom v. Consolidation Coal Co., 7 B.L.R. 1-582 (1984).

Dr. Branscomb, a Board-certified Internist, issued four consultative reports, dated from September 1998 through May 2002. He opined that there is no objective data indicating the presence of any primary pulmonary disease. Following his review of medical opinions, pulmonary function tests and arterial blood gas studies taken between 1990 and 2001, he wrote that it is "exceedingly common" and "usual" to observe restrictive and obstructive impairments in a person with chronic left ventricular failure, an enlarged heart, and a previous sternum-splitting operation (EX 2). According to Dr. Branscomb, the impression of dyspnea or difficult breathing noted by some observers is "most likely due to observation of hyperventilation," and that hyperventilation can be explained by "fear, anxiety, pain, or some other non-medical process" (EX 2). Dr. Branscomb gave the reasons for his conclusions and identified the tests upon which he relied in making his diagnosis. He reviewed medical evidence from eleven years of evaluations of the Claimant. Although he is not an examining physician, I find that his opinion is reasoned, documented, and entitled to substantial weight.

Dr. Simpao opined that the Claimant is totally disabled due to pneumoconiosis. Dr. Simpao examined the Claimant five times between March 4, 1997 and October 3, 2001. During his examination of the Claimant, he took histories, conducted a physical exam, and administered pulmonary function tests and arterial blood gas studies. He opined that the Claimant has a pulmonary impairment that would prevent him from performing his usual coal mine employment, and his history of coal mine dust exposure is medically significant in his pulmonary impairment (CX 2). Although he reported a smoking history of one pack of cigarettes per day for nine years and noted that the Claimant suffers from heart disease and diabetes, Dr. Simpao did not mention what effect the Claimant's smoking history, heart disease, and diabetes could have on his pulmonary impairment. Dr. Simpao wrote that he based his conclusions on the testing he performed, symptomatology, and physical findings. However, he cites only the Claimant's pulmonary function test as the basis for his opinion that the Claimant has a totally disabling respiratory impairment. I accord Dr. Simpao's opinion less weight because his pulmonary function tests were found to be invalid, and because he does not explain how he arrived at his conclusion or whether the Claimant's smoking history, heart disease, and diabetes had an effect on his respiratory impairment. As such, I find his opinion is not well reasoned or supported by the evidence of record, and is entitled to less weight.

Additionally, I note that Drs. O'Bryan, Fino, and Branscomb are Board-certified Internists, Dr. Fino is a B reader, and Dr. O'Bryan is a Pulmonologist and Critical Care Physician. The record does not contain evidence that Dr. Simpao has comparable specialized diagnostic skills.

Under § 718.204(b)(2)(iv), all evidence that is relevant to the question of total disability is to be weighed, with the claimant bearing the burden of establishing total disability by a preponderance of the evidence. See Mazgaj v. Valley Camp Coal Co., 9 B.L.R. 1-201, 1-204 (1986). For the reasons stated, I find that the opinion of Dr. O'Bryan, the highly qualified examining physician, together with the opinions of Drs. Fino and Branscomb, the highly qualified consultants, outweigh the opinion of Dr. Simpao. Therefore, I find that the evidence is not sufficient to establish total disability due to pneumoconiosis.

VII. ENTITLEMENT

The Claimant, Harold Ray Smith, has not shown a material change in conditions and, therefore, has not established entitlement to benefits under the Act.

VIII. ATTORNEY'S FEES

An award of attorney's fees is permitted only in cases in which the claimant is found to entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

IX. ORDER

It is, therefore,

ORDERED that the claim for benefits by Harold Ray Smith is hereby DENIED.

A

Robert L. Hillyard
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board, P.O. Box 37601, Room S-5220, Washington, D.C., 20013-7601. A copy of this Notice of Appeal must also be served on Donald S.

Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.